UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

BUTALBITAL-CONTAINING PRODUCTS

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION TO 855-828-4992

CRITERIA

As established in the U.S. Headache Consortium's evidence-based guidelines for migraine treatment

- Minimum age requirement: 18 years old
- Trial and failure of:
  - one or more non-steroidal anti-inflammatory agent
    AND
  - one or more triptans (any administration route)
    AND
  - intranasal dihydroegotamine
    AND
  - butorphanol
    AND
  - an acetaminophen-codeine combination product
    AND
  - an aspirin-caffeine-acetaminophen combination product
- A letter of medical necessity detailing the patient's unsatisfactory response to each agent above.

AUTHORIZATION:
6 months

RE-AUTHORIZATION:
Written request from physician demonstrating that the patient's response to the butalbital-containing product is positive, AND that the patient's response to the butalbital-containing product is significantly better than to products that do not contain butalbital.